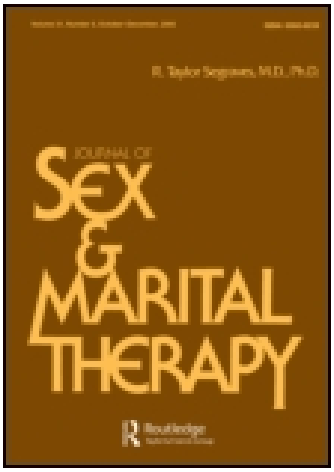

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Prevalence and Correlates of Childhood Sexual Abuse in Adults Consulting for Sexual Problems

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The main objectives of the study were to assess the prevalence of childhood sexual abuse in individuals consulting for sexual therapy and to explore the association between a history of childhood sexual abuse and psychological and couple functioning. A sample of 218 adults receiving sex therapy completed questionnaires assessing depressive and anxious symptomatology, as well as dyadic adjustment. Prevalence of childhood sexual abuse was high in women (56%) and men (37%), and clients with a history of childhood sexual abuse were more likely to report psychological and relationship problems. Findings should aware clinicians of the need to assess sexual trauma and related outcomes.

A history of childhood sexual abuse (CSA) is reported by a significant proportion of men (8%) and women (18%) in community samples (Stoltenborgh, Van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011). Within clinical populations, rates of CSA appear definitely higher. For example, between 60% and 80% of women diagnosed with borderline personality disorder (Bouchard, Godbout, & Sabourin, 2009; Zanarini et al., 2002) and 46% of adult inpatients in a psychiatric hospital (Wurr & Partridge, 1996) report CSA. Despite the high prevalence in clinical samples and a continually growing body of research evidence underscoring the negative consequences of CSA, few empirical reports have documented the prevalence and correlates of CSA in clients receiving individual or couple sex therapy. One notable exception is Sarwer and Durlak (1996) who have reported rates of 20% of CSA in their sample of 359 women receiving couple sexual therapy. However, this rate appears similar to the one established in the general population (Stoltenborgh et al., 2011) and largely below the rates found in other clinical samples (Bouchard et al., 2009; Wurr & Partridge, 1996; Zanarini et al., 2002). This apparent discrepancy calls for further study on the prevalence of CSA in this specific population. In addition to the scarce data

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on the prevalence of CSA in adults consulting for sexual problems, further empirical studies on the prevalence and correlates of CSA in adults consulting in sex therapy are required for three main reasons:

First, many studies have documented the association between CSA and adult sexual life, yet results remain inconsistent. Although the majority of studies found a positive correlation between CSA and difficulties related to adult sexual health (Eadie, Runtz, & Spencer-Rodgers, 2008; Lacelle, Hébert, Lavoie, Vitaro, & Tremblay, 2012), sexual dysfunctions (Luo, Parish, & Laumann, 2008; Sarwer & Durlak, 1996; Senn, Carey, & Vanable, 2008; Zwickl & Merriman, 2011) or levels of sexual satisfaction (Bartoi & Kinder, 1998; Easton, Coohey, O'Leary, Zhang, & Hua, 2011; Lemieux & Byers, 2008; Meston, Rellini, & Heiman, 2006; Rellini & Meston, 2011; Stephenson, Hughan, & Meston, 2012), other studies failed to find such associations (Dennerstein, Guthrie, & Alford, 2004; Greenwald, Leitenberg, Cado, & Tarran, 1990; Hullfish et al., 2009; Meston, Heiman, & Trapnell, 1999). In interpreting these results, it is important to consider that the majority of studies involve samples recruited in the general population or in colleges and rarely in clinical settings. In addition, as illustrated by Rellini and Meston (2007), the discrepancy in the association between CSA and adult sexual function may depend in part on the different definitions of CSA used by researchers. From a clinical point of view, CSA has been associated with different levels of symptom severity and one of the critical variables linked to psychological and/or sexual adaptation may relate to personal factors such as the way survivors are able to mentalize about their experience (Fonagy, Steele, Steele, Higgit, & Target, 1994). However, psychological processing of trauma has rarely been assessed, which might account for some of the differences observed in the empirical literature. Thus, CSA histories in clients consulting for sex therapy remain insufficiently documented and, consequently, the mechanisms by which CSA may affect adult sexuality remain misunderstood.

Second, in the past two decades, studies have highlighted the effect of CSA in terms of psychological distress and, more recently, romantic relationships. Different meta-analyses confirmed the long-term effect of CSA on psychological health (e.g., Maniglio, 2009; Neumann, Houskamp, Pollock, & Briere, 1996; Paolucci, Genuis, & Violato, 2001). The scientific literature established that CSA increases the risk of marital problems such as couple distress, chronic dissatisfaction, insecure romantic attachment with fear of abandon and intimacy avoidance, and union dissolution (Godbout, Lussier, & Sabourin, 2006; Godbout, Sabourin, & Lussier, 2007; see review by Davis & Petretic-Jackson, 2000; DiLillo, 2001; Rumstein-McKean & Hunsley, 2001). In brief, CSA is related to significant impairments in the general population. If similar findings were observed in clinical samples consulting for sexual problems, the question of whether treatments should go beyond an exclusive focus on adult sexuality and include trauma issues will be relevant.

Last, data on the prevalence and correlates of CSA in clients consulting for sexual problems could offer cues to evaluate whether the goals, sequence of the treatment's objectives, and possible outcomes following therapy should be similar for clients who endured sexual trauma in childhood. On the one hand, Hall (2008) expressed concerns as to the possible negative effects of some specific therapeutic strategies with CSA survivors, given that prescribing sexual activities or behaviors might indirectly reproduce various aspects of the experience of victimisation. Some researchers (e.g., Glantz & Himber, 1992; Maltz, 1988) have proposed modifications to standard sex therapy that take into account the specific symptoms and concerns of CSA survivors, but empirical evidence confirming the necessity to modify well established therapies is sparse. On the other hand, Sarwer and Durlak (1997) identified that a history of CSA did not interfere with

the efficacy of their intervention with adult couples. However, a surprisingly low prevalence of sexual abuse was found in their study, which may reflect a less sensitive or detailed assessment of CSA. Given the limited scientific literature on the topic, more research is needed in order to establish the prevalence and correlates of CSA in individuals consulting in sex therapy.

In summary, clinicians offering sex therapy have insufficient research-based information given the lack of empirical data on the prevalence of CSA in adults consulting for sexual problems and associated correlates. This represents a definite scientific and clinical issue because CSA might have an important effect on the client's clinical presentation at intake. This study addresses these concerns by offering preliminary data concerning the prevalence and correlates associated with a history of childhood sexual abuse in clients consulting for sexual problems. More precisely, the study aims to evaluate the association between CSA and depressive symptoms, symptoms of anxiety and couple functioning. These data are likely to offer interesting implications for clinical practice in addressing specific factors that might be related to clients' progress in therapy.

METHOD

Participants

The sample consisted of 218 adults (104 men and 114 women) consulting for sexual problem (e.g., sexual dysfunction, sexual dissatisfaction). Clients were recruited in different clinical settings, such as medical clinics or general services of hospitals ($n = 18$), private practice ($n = 16$), units specialized in sexual disorders ($n = 123$), organizations offering health services to the community ($n = 44$), or other clinical settings ($n = 17$), thus reflecting the wide areas of sex-related services offered to the population. More than half of participants consulted in individual therapy (55%) and the other half consulted as a couple (45%). Clinical assessment was provided by graduate interns completing a supervised clinical internship in sexology. The mean age was 36 years ($SD = 12.72$, ranged from 17 to 75). The majority (75%) attained at least a college-level education and 83% were involved in a relationship (dating, cohabiting, or married). Concerning annual income, 45% of participants reported less than CND$20,000, 35% between CND$20,000 and CND$40,000 and 20% reported income more than CND$40,000. The majority of participants were born in Quebec with French as their primary language (90%).

Measures

In addition to items concerning sociodemographic information, a battery of questionnaires assessing different spheres of functioning was completed by participants. A French adaptation of the Sexually Victimized Children Questionnaire (Finkelhor, 1979) was first used to evaluate the presence and characteristics of CSA episodes in participants' history. The participants were asked to indicate if they were victim of a number of different unwanted sexual experiences in childhood such as "an adult touching your sex parts." For the present study, two groups were formed as a function of participants' self-report of CSA. Individuals who indicated having experienced intrafamilial (CSA perpetuated by a member of the immediate or extended family) or extrafamilial sexual abuse were included in the group of survivors of CSA. Behaviors indicative of sexual abuse, referred to unwanted sexual contacts including (a) someone exposed his sexual parts or

forced the participant to do so; (b) someone touched or tried to touch the sexual parts of the participant, or forced the participant to touch him or her; (c) someone had, or tried to have, sexual intercourse (oral, anal, or vaginal), using threat or constraint.

Two measures evaluated psychological functioning. First, the Beck Depression Inventory (Beck, Ward, Mendelson, Jock, & Erbaugh, 1961) was used, to assess depressive symptomatology. This self-report instrument includes 21 items and evaluates the severity of the depressive symptoms reported (mild, moderate, severe). Participants are asked to indicate on a Likert-type scale how they have been feeling in the last week. An example of an item is (0) "I do not feel sad"; (1) "I feel sad"; (2) "I am sad all the time and I can't snap out of it"; (3) "I am so sad or unhappy that I can't stand it." The measure has well-established psychometric properties (Beck, Steer, & Garbin, 1998). Second, the State-Trait Anxiety Inventory (Spielberg, Gorsuch, Lushene, Vagg, & Jacobs, 1983) was administered to evaluate symptoms of anxiety. The inventory includes separate measures of state and trait anxiety. The state-anxiety scale consists of 20 statements that evaluate how the participant feels "at this moment," such as "I feel upset." The trait-anxiety scale also consists of 20 statements, assessing how the participants feel "generally," such as "I lack self-confidence." The State-Trait Anxiety Inventory is a widely used measure of anxiety and has well-demonstrated psychometric properties (Barnes, Harpes, & Jung, 2002).

The Dyadic Adjustment Scale (Spanier, 1976, translated in French by Baillargeon, Dubois & Marineau, 1986) was administered to assess participants' couple functioning. The instrument includes 32 items such as "Please circle the dot which best describes the degree of happiness, all things considered, of your relationship," rated on a 7-point scale ranging from 0 (*extremely unhappy*) to 6 (*perfect*). The scale evaluates four dimensions (consensus, satisfaction, cohesion, affectional expression) to assess the overall degree of partners' satisfaction with their romantic relationship. High scores reflect elevated dyadic satisfaction. The reliability of the French adaptation of the Dyadic Adjustment Scale (α range between .91 and .96) and its convergent and discriminant validity have been confirmed in several studies (e.g., Sabourin, Valois, & Lussier, 2005).

Procedure

During the first meeting with their clients, therapists explained the research project and interested clients completed the consent form. A clinical profile of the results was provided to the therapist and his or her clinical supervisor in the course of the evaluation process. Confidentiality was protected by the attribution of a numerical code for each participant. This research was approved by our university's institutional review board.

Analytic Strategy

We performed preliminary group comparisons to compare CSA survivors and participants without history of CSA on their sociodemographic characteristics, using chi-square analysis (for categorical variables such as annual income) and with Mann-Whitney nonparametric analysis (for continuous variables such as age). Next, Mann-Whitney group comparison, Fisher's exact test, and *t* test were performed to compare CSA survivors and participants without history of CSA on scales of depression, anxiety and dyadic adjustment, based on the characteristics of the data. All analyses were performed using SPSS.

TABLE 1
Characteristics of Childhood Sexual Abuse

	Women		*Men*	
Characteristics	*n*	%	*n*	%
Type of childhood sexual abuse ($n = 102$)				
Intrafamilial	25	39	15	40
Extrafamilial	39	61	23	60
Severity ($n = 102$)				
Exhibitionism	5	8	3	8
Touching	29	45	18	47
Penetration	30	47	17	45
Frequency ($n = 102$)				
Unique episode	21	35	6	17
Few episodes (2–3)	15	25	11	32
Repetitive or chronic	24	40	18	51
Age at first abuse ($n = 95$)				
Preschooler (0–6 years)	10	16	7	18
School age (7–12 years)	25	41	19	46
Adolescence or young adult (>12 years)	26	43	8	36

RESULTS

Sample Characteristics

The analysis revealed that 37% of men ($n = 38$) and 56% of women ($n = 64$) receiving services in sex therapy reported a history of CSA. The characteristics of the CSA experienced are presented in Table 1. The data indicate that 73% sustained more than one episode of sexual abuse; that 39% of the acts were perpetrated by a member of the family and that the majority of CSA (92%) involved physical contacts. No significant difference was observed between sociodemographic characteristics of the two groups (CSA survivors or no history of CSA). Moreover, participants from the different clinical settings were not different in terms of history of CSA and sociodemographic characteristics. Thus, these variables were not controlled in following analyses.

CSA, Depression, and Anxiety

Mann-Whitney nonparametric analysis, *t* tests, and Fisher's exact test analysis revealed significant differences between survivors of CSA and clients without such history. Survivors of CSA were more likely to present symptoms of depression (25%) than clients without history of CSA (12%), $\chi^2(1, N = 216) = 5.44$, $p = .02$, $\phi = .16$. In addition, all clients ($n = 10$) presenting a clinically significant level of depressive symptoms also reported CSA (Fisher's exact test $< .001$). Furthermore, CSA survivors scored significantly higher on the measure of trait anxiety ($M = 62.83$, $SD = 12.41$), than clients without such history ($M = 57.47$, $SD = 9.56$), $U = 2500$, $z = -2.70$, $p = .007$, as well as on the measure of state anxiety ($M = 57.55$, $SD = 12.20$) than clients without victimisation history ($M = 52.56$, $SD = 8.75$), $U = 2491$, $z = -2.61$, $p = .009$.

TABLE 2
Means and Standard Deviations of the Dyadic Adjustment Scale, in Function of Childhood Sexual Abuse Severity

	Less severe or no childhood sexual abuse (n = 142)		*Severe childhood sexual abuse (n = 40)*		
	M	SD	M	SD	p
Dyadic cohesion	54.38	9.39	52.15	9.01	.182
Dyadic satisfaction	41.70	10.09	37.78	9.09	.028*
Affectional expression	41.24	11.50	37.63	10.86	.077
Dyadic consensus	46.35	9.84	41.85	9.85	.01*
Dyadic adjustment	45.17	9.87	40.40	9.20	.007*

CSA and Dyadic Adjustment

CSA survivors ($M = 43.26$, $SD = 10.42$) initially did not appear different from clients without CSA in terms of couple functioning ($M = 44.91$, $SD = 9.35$), $t(177) = 1.12$, $p = .27$. However, as shown in Table 2, when individuals who experienced penetration or penetration attempt were compared with those without history of sexual abuse involving penetration, results of a t test showed that sexual abuse involving penetration has a significant negative effect on dyadic adjustment and the subscales of dyadic satisfaction and dyadic consensus, with substantial effect sizes (Cohen's $d = .50$, .41, and .46, respectively). In other words, the influence of CSA on couple functioning largely depends of the intrusive nature of the abusive behaviors.

DISCUSSION

Results first suggest that CSA is prevalent in individuals consulting for sex therapy, with close to half of clients reporting a history of CSA. These rates, among women (56%) and men (37%), are more than three times higher than those reported in the general population (Stoltenborgh et al., 2011). CSA thus appears as a central aspect of the clinical presentation of adults consulting for sexual difficulties. A recent study (Hébert, Tourigny, Cyr, McDuff, & Joly, 2009) suggested that most CSA survivors do not disclose (21%) or considerably delay disclosure (58%). The present study was characterized by a direct inquiry about CSA in the context of an ongoing sex therapy. This particular evaluation process might have offered an optimal opportunity for disclosure, which would result in higher rates of CSA compared with those obtained in other contexts.

Second, results indicate that clients of sex therapy with a history of CSA are at risk to present more severe symptoms of psychological distress compared with clients without CSA, and that those who have experienced abuse involving penetration are more likely to have couple functioning issues. Thus, CSA is not only prevalent in individuals presenting sexual difficulties, but it is also associated with a more severe clinical presentation at intake. Not only clients with CSA history were more likely to present symptoms of depression at intake, but all the clinically depressed clients were CSA survivors. CSA survivors also showed more traits and states of anxiety at the beginning of the therapy than clients without victimisation history. Victims of abuse

involving penetration or penetration attempts also showed more impaired dyadic adjustment. Results suggest that sexual victimisation is a complex phenomenon and that abuse involving more intrusive behaviors lead to an increased risk of couple difficulties, as proposed by previous studies (Watson & Halford, 2010). This link between CSA and dyadic adjustment may also be indirect; the present study confirms previous observations concerning the associations among CSA, anxiety, and depression, yet the scientific literature suggests an indirect link between CSA and dyadic adjustment through the effect of psychological distress (Godbout et al., 2006). Our results with regard to the specific effect of CSA with penetration underscores the importance of rigorously defining the term CSA when collecting data for research or assessing clients in clinical settings. In conclusion, a significant proportion of clients seen in sex therapy are characterized by a complex clinical presentation, related to their history of CSA and subsequent psychosocial effects. Trauma-related symptomatology is susceptible to impede on several domains of functioning and may as well influence course of therapy.

Our results underline the importance of documenting the potential challenges that CSA may represent for clients and therapists in clinical sexology. It is likely that if clinicians are not informed of their client's history of CSA, and of the effects of these traumas, the treatment offered will face important resistances that might hamper effectiveness and slow down progress. Some typical symptoms of CSA, namely dissociation and avoidance of trauma-related cues, may interfere with clients' cognitive processes within the sessions, and the observance of prescribed exercises. In addition, as suggested by Hall (2008), the prescription of specific sexual behaviors might be experienced by some victims as particularly intrusive and might trigger negative transference (Maltz, 2002). Thus, multimodal interventions which take into account different dimensions of trauma, such as feelings of blame, self-assertiveness, respect of personal boundaries, and the different comorbidities, should be privileged. Extended recommendations have recently been expressed (see Briere & Lanktree, 2011; Cloitre, Cohen, & Koenen, 2006; Maltz, 2002) stating that multimodal interventions adapted to the specific needs of CSA survivors need to be implemented to promote treatment effectiveness. Consequently, brief therapy format of standard sex therapy might not be well suited for survivors of sexual trauma.

The present study has many strengths such as the assessment of CSA with a sensitive questionnaire giving access to a classification of the severity of the experience of victimisation, and the inclusion of a meaningful number of participants all receiving sex therapy in a variety of clinical settings, thus representing the general services offered to the population. The inclusion of participants consulting in a diversity of clinical settings represents a strength and a limitation of the present study. Although this increases the ecological validity of the results, clients from distinct clinics may show differences in their history, clinical presentation and motives for coming to therapy. Another limitation of the present study lies in the fact that we did not evaluate whether participants were taking psychoactive medication when assessing anxious and depressive symptomatology.

The mechanisms by which CSA may affect adult sexuality remain misunderstood. Recent developments in this area have shown that sexual self-schemas, mainly the representation of the self in relation to sexuality, mediate the association between CSA and negative affects during sex with a partner (Meston, Rellini, & Heiman, 2006). A recent study showed that more embarrassed/conservative and less romantic/passionate sexual self-schemas predicted negative affect prior to exposure to sexual stimuli which, in turn, predicted levels of sexual satisfaction, suggesting that negative sexual self-schemas contribute to reduce sexual satisfaction partly through the

activation of negative affect prior to sexual experiences (Rellini & Meston, 2011). Such findings have implications for clients with a history of CSA consulting for sexual difficulties and further research is needed on the mediators and moderators in the relation between CSA and adult sexual adjustment.

Future studies should also explore the effect of CSA on the outcome of sex therapy. In addition, analyses should consider whether the sequence of objectives planned by the therapist need to be adapted for survivors of CSA, in considering for example CSA and associated symptoms as initial or concomitant treatment objectives. It is interesting that Brotto, Basson, and Luria (2008) showed that a mindfulness-based intervention targeting sexual arousal disorder was associated with more improvement in women with a history of sexual abuse than in women without such history. Given that mindfulness-based therapy is proposed as an intervention well-suited for survivors of trauma (Follette, Palm, & Pearson, 2006; Follette & Vijay, 2009), it may be that this specific approach provides a feeling of safety by facilitating emotion regulation in survivors, helping to direct attention toward pleasant sexual feelings from moment to moment as the interaction is unfolding. Thus, CSA should not necessarily be seen as a factor hampering treatment efficacy but as a variable that may call for adaptations to the traditional sex therapies on the basis of the clinical and scientific knowledge about interventions with survivors of traumas. In addition, according to the social-cognitive processing model of adjustment to trauma (Belsher, Ruzek, Bongar, & Cordova, 2012) discussing trauma-related thoughts and emotions with supportive others might play a key role in the process of recovery. Consequently, not only the therapist but also the spouse or intimate partner might be seen as a partner in healing. In this context, partners might benefit from education about the consequences of trauma regarding possible strategies to optimize the intimate relationship and the sexual sphere (Maltz, 2012).

Clinicians should be aware of the importance of documenting abuse history in their clients, not only because it is frequent and related to clients' presentation, but also because it might be of crucial importance for treatment effectiveness. Results of the present study clearly confirm the importance of documenting CSA history in the context of individual or couple therapy and support the importance of heightening clinicians' awareness of the need to assess sexual trauma and related outcomes.

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